

Abstract

Background

The public health argument for developing and maintaining workplace wellness programmes in organisations is well-documented, particularly within the healthcare sector who aim to 'set the example' for workplace health. However, workplace wellness also makes good business sense, since it is established that investing in employee health can reduce absenteeism, improve job satisfaction and productivity and enhance corporate image.

Purpose

Organisations often place workplace wellness low in their priorities yet this article presents the case for an initial resource investment and top-level support to pump-prime a financially sustainable and even profitable programme.

Approach

A discussion is presented based on academic literature and practical applications from our own experiences in practice.

Findings

We use our in-house scheme, 'Q-active' as a case example based in an NHS Trust setting, to demonstrate how such schemes can be developed and successfully implemented and maintained.

Value

Workplace wellness schemes are financially viable and can become a vital part of a large organisations' infrastructure embedded within policies and internal 'health culture'.

The price is right: Making workplace wellness financially sustainable

The emergence of academic journals and publications specifically relating to workplace health demonstrates that the concept of workplace wellness is increasingly on the radars of policy makers, employers and employees alike. Although individuals are responsible for their own health in terms of their level of physical activity during the working day, the food choices they make and the ways in which they deal with workplace stress employers have a corporate responsibility for putting systems into place which allow their employees to make informed choices about their health and act on them (World Business Council for Sustainable Development, 2000). Employee lifestyle choices also impact heavily on the overall health and wellbeing of the workforce with obvious consequences for sickness absences, recruitment and retention of staff and job satisfaction (Chapman, 2003; Okie, 2007). The case for workplace wellness initiatives is therefore irrefutably based in common sense. Whilst this growing knowledge and associated changes in practice are encouraging and support government drives to improve population health through a 'settings' approach to health promotion, advocates are invariably asked the same basic question:

"How can I implement a workplace wellness programme in my organisation without funding?"

We acknowledge this conundrum as employers struggle to allocate limited resources in the best possible way, whilst acknowledging their own corporate social responsibility to protect and promote the health and wellbeing of their workforce. However, our own experiences have shown us that the answer to this question is clear and is presented here in the context of our own (funded) workplace wellness programme as a case study example.

In brief, our response is indisputably that implementing employee wellness without financial backing is not effective. Nevertheless, it is possible for such a programme to become financially sustainable after an initial investment period. It is unfortunate that many organisations and policy-makers do not yet see workplace wellness as a priority, rather it is often viewed as the 'cherry on the cake' instead of a crucial part of the infrastructure. The moral, health and corporate responsibility arguments have been well documented by previous authors (Dishman, 1988; Shephard, 2002; Proper, 2003; British Heart Foundation, 2005) but have yet to convince many to adopt such policies. Our argument is that workplace wellness programmes *can* be implemented for financial and tangible gains, and are not just expressions of goodwill or to be seen to be 'ticking the right boxes'.

Background

The National Institute for Health and Clinical Excellence (NICE) have recently produced guidance on workplace health promotion (NICE, 2008). Part of this includes a practical tool to assist organisations with analysing the costs associated with implementing such a programme. The NICE report purports that addressing the health and wellbeing of the workforce is imperative for organisational accomplishments and states that, "a healthy, committed workforce is vital to business success".

The problem – providing a convincing business case for workplace wellness

In deciding whether or not to implement a new initiative, all organisations need to consider the business implications, as well as the social and ethical arguments of doing so. Physical inactivity is becoming more prevalent in society and preventable disease associated with sedentary lifestyles, overweight and obesity is increasing at an alarming rate (Booth et al, 2000; Department of Health, 2004). Recent estimates put the direct cost of UK overweight and obesity to the NHS at £3.2 billion, equating to 4.6% of total NHS expenditure in 2002 (Allender & Rayner, 2007), whilst the estimated direct cost to the NHS of physical inactivity was approximately £1.06 billion in 2002 (Allender et al, 2007). These estimates do not take into account indirect costs such as days lost to sickness absence and premature mortality, private healthcare costs and homecare. The indirect UK healthcare costs of cardiovascular disease alone have been estimated as a further £21 billion in 2003, around 60% of the total cost (Leal et al, 2006).

The extensive economic costs of current poor health-related behaviour and the potential savings of changes to this behaviour serve as a powerful justification for organisations, particularly healthcare managers to develop health promotion programmes. However, despite the evident societal and larger scale population-level costs, producing an accurate individual business case for workplace health is problematic as there are both direct and indirect costs associated with the schemes, quantifiable and less tangible benefits that are proving difficult to measure. This paper focuses on the healthcare sector, although its case can be equally applied to other large organisations.

It can be argued that most health care providers have a short-term narrow-minded financial perspective and so are thereby unable to utilise the long-term holistic view that cost-effectiveness analysis requires (Berger, 1999). In private business, the bottom line is 'income versus expenditure'; the public sector must make economic decisions based on effective interventions that provide the most *benefits* relative to

costs, although the trend towards Corporate Social Responsibility is altering this slightly for private organisations. Therefore, as Grosse et al (2007) stated, cost-effectiveness estimates are in fact a 'decision aid', not a 'decision rule'. Resource allocation is also complicated by the lack of reliable evidence of effectiveness in terms of outcomes (health or otherwise) and so frequently decisions must be based on a subjective, value-laden process in which economic methods are combined with stakeholder input, not to mention trends and current targets.

The case for workplace wellness schemes – initial investment

Tangible benefits:

In 2006, 175 million working days were lost to sickness absence in the UK, costing the economy £13.4 billion (CBI, 2007) and employers 8.4 working days per employee per year. However, we know that promoting physical activity in the workplace can reduce absenteeism by up to 20% as active employees take 27% fewer sick days (Health, Work and Wellbeing Programme, 2008). Workplace wellness schemes that include a physical activity promotion element may therefore impact on economic costs to the organisation.

There is little published evidence available from the UK regarding the cost-benefit relationship offered by employee wellness schemes, although work has been conducted to this effect in the US. For example, Aldana (2001) reviewed 14 health promotion programme evaluations and summarised that all the measures resulted in a reduction in absenteeism of approximately 34% in the costs associated with absences from work. Three of the studies reviewed established the cost-benefit ratio and return of investment at roughly \$2.5 per dollar spent on the programme. Again this work supports the economic benefits of workplace wellness programmes in terms of reductions in employee absenteeism.

Wellness schemes can also impact on staff turnover and improve job satisfaction, which are known to increase productivity (Schultz & Edington, 2007; Renaud et al, 2008). Average annual turnover in the UK is 18.1% (Chartered Institute for Personal Development, 2007). However, it is suggested that well-designed wellness programmes can increase employee job satisfaction and reduce staff turnover by between 10 and 25% (Pricewaterhouse Coopers, 2008). Further, whilst the direct cost of absence has been estimated at £438 per employee per year (CBI, 2000), the CBI's

work in this area also estimates that the indirect cost of absence alone is typically three of four times a direct cost.

Less tangible benefits:

The more complex part of the business case is quantifying the less tangible, but equally valuable, benefits of employee health programmes. These include an improved corporate image, corporate social responsibility, morale and employee satisfaction and productivity (termed 'presenteeism'). It has been suggested that presenteeism may cost businesses financially more than absenteeism (Collins et al, 2005). Thus, it has been concluded that well-implemented, multicomponent health promotion programmes may not only improve the health status of participants, but also improve their work performance (Mills, et al, 2007).

Estimating the societal costs of inactivity and related ill health is complicated (Hagberg & Lindholm, 2004). A good economic evaluation, on which resource-allocation decisions are based, should take into account both costs and consequences of sickness absence, poor morale, high turnover, decreased productivity ('presenteeism') and so on, and is thus very complex. It is known that health promotion initiatives have an impact on many aspects of the social environment, including health care, productivity and the economic impact on participants (Stohols, 1992; Posnell & Jan, 1996; NAO, 2001). Time invested by individual participants is frequently viewed as one of the largest resources involved and should therefore be taken into account when calculating the costs of workplace wellness and benefits to both the organisation and the employees. A key issue is whether engagement in physical activity is viewed as part of the individual's own leisure time or represents lost leisure time (Hagberg & Lindholm, 2004). Whilst previous research has examined individual motivations for activity to clarify this (Biddle & Fox, 1998; Sallis & Hovell, 1990; Trost et al, 2002), in actual fact, employers providing physical activity opportunities at work alter this debate significantly with the key decision becoming: is the time spent in physical activity during working hours taking participants away from their work (e.g. an organisational cost) or investing in their future productivity, health, morale and commitment (e.g. organisational benefits)?

One important factor in cost-effectiveness decision making is evaluating the effectiveness of the proposed intervention. Hagberg & Lindholm (2004) suggested that this can depend on the target population; for example, "the preventive effect is 2.5 times higher for those with the poorest fitness compared with those at moderate fitness levels. The gains will be even higher if the target group has poor health and

there are both preventive and treatment effects” (p.8). Therefore, they conclude that cost-effectiveness and changes in equity in health are two important aspects in every decision when a programme will be implemented with a restricted budget.

The problem that presents itself to motivated but resource-scarce organisations (or more often, enthusiastic individuals within organisations) is one of producing a convincing, evidence based cost-effectiveness analysis that will convince the decision makers to invest in a long term multi-component workplace wellness programme, rather than a one off short-term ‘tick-box’ exercise.

The long-term case for workplace wellness schemes – Q-active

Our solution was to run a wellness scheme like a business, therefore negating the need for complex financial ‘wrangling’ and obtaining data that in a large-scale organisation may be difficult to collect or inaccurate (e.g. sickness absence data). We set out to launch a workplace wellness programme for our staff at a large Acute teaching hospital that would eventually become self-sustaining. In this instance, it was fortunate that dedicated individuals were available to invest the time, resources and enthusiasm required to be innovative and ‘trail-blaze’. We are therefore keen to share our learning with the aim of inspiring others to do likewise. However, in our opinion this model of practice may only be effective within a large, open-minded organisation.

Q-active, based at the QMC Campus of Nottingham University Hospitals NHS Trust in Nottingham, was one of the first dedicated projects devoted to improving the health and wellbeing of staff in a UK healthcare setting. As part of the lottery-funded Active England programme, this innovative initiative was developed in direct response to the government’s call for healthcare settings to ‘set the example’ for workplace health through the Choosing Health White Paper (Department Health, 2004). Q-active aimed not just to promote the health and physical activity levels of staff, but to change the health culture of a large NHS organisation using an ecological multi-component approach based heavily on increasing physical activity levels amongst staff but also incorporated other important elements of workplace health promotion including health screening, healthy eating campaigns, and stress management.

Like any business, Q-active required start-up investment. As Bull et al (2008) concluded, workplace health programme success and sustainability is much more likely when sufficient time and resources are allocated. It was initially funded for three

years, which provided a full time, dedicated project manager, part time administrative support, capital funding for facilities (which was not absolutely essential but useful) and enough revenue to provide marketing material.

Once the necessary staff were in post, we approached the programme with a number of goals, including an academic remit – to contribute to the evidence base for such programmes – and a business aim to ensure that the programme was financially sustainable at the end of the initial funded period. These two aims complemented each other as we carried out a full needs analysis, which in business terms meant that we completed the required market research to understand our ‘customers’ in order to pitch our product correctly, and allowed us to identify the main barriers and determinants to workplace health promotion (time, motivation, culture etc), along with the competition.

The baseline research enabled us to understand the nature of our target market (overweight, inactive, stressed NHS staff), the local environment (a large landlocked building with unexploited activity opportunities, few healthy eating outlets and a health behaviour culture of “do as I say, not as I do”), and the management culture (“why are you talking to us about staff health and wellbeing, have you seen our financial position?”). We then produced a business plan and set our objectives accordingly.

Our first task was to obtain investment in the form of top level support. High level managerial support has been identified as the most important factor in determining the success of workplace wellness schemes (Blake and Lloyd, 2008). However, in practice this was extremely difficult in an environment of change and financial instability present at the time and it is hoped that our experiences will assist future health promoters with this. We then created a strong recognisable brand image to enable us to market our product effectively. As health promotion experts, we have an in depth knowledge of our product (health behaviours) but can suffer the problem that it is often viewed negatively by our customers (e.g. telling people how they should behave).

In our Trust, exercise was often viewed by staff as a ‘chore’ that takes valuable time away from other more important tasks; healthy eating as a luxury for people not working shifts or having easy access to cheap, nutritious foods; taking breaks and stress management for people that are not employed by the NHS! Therefore, we had to find ways to reframe our product in a way that was palatable to our target market.

We chose a Social Marketing approach to address this and reframe the traditional health messages, which is currently being evaluated and will be published shortly.

After the initial six month period of research and planning, we launched the programme. Initially we concentrated on providing activity classes for staff within a 'wellbeing room' and walking classes outside the grounds. We found that short, lunch time classes were the only viable ones initially, since staff were reluctant to stay behind in the workplace after their work shifts to participate, although that did mean that the classes tended to appeal mainly to administrative staff that could easily take an hour for their lunch break. Healthcare professionals have been harder to access. Instructors were employed on a self-employed basis (although many were also Trust employees) and paid using a sliding scale depending on numbers of participants. We charged discounted realistic prices, which added a perceived quality to the product, and thus the classes broke even within three months of launch. We also hired out the room facility to freelance holistic therapists (also Trust staff) providing additional revenue and services for our employees. Thus, within a short time, our activities were financially self-sustaining.

However, in order to maintain their use and to reach other staff, we needed to run large-scale events, maintain a dedicated website, hold departmental wellness checks, have our own merchandise/'freebies', run social marketing campaigns, all of which are expensive, and so we needed to raise extra revenue for the future. We therefore looked for ways to expand our services.

Over the following two years, Q-active launched a number of revenue-boosting initiatives including a membership scheme, where staff paid £10 for six months giving them 25% off activities; a student service, where we provided access to activity classes for healthcare students using a University grant to allow us to charge subsidised rates, a staff gym by allowing access to the physiotherapy patient gym out of 'patient' hours, community wellness checks where we charged organisations to run our wellness checks at community events. Finally, we have franchised to the University and to our other main site, effectively doubling our income (and workload) and, in partnership with the in-house catering team, have launched smoothie bars in the catering outlets and ring-fenced the income for Q-active.

Whilst we have had to make countless arguments to Trust Directors, staff side and other stakeholders, Q-active has been a triumph of innovation, enthusiasm, partnership working and a belief in our programme. Three and a half years after launch, six months after the initial funded period, we now earn up to £50,000 a year

profit and provide the social, organisational and physical environment for Trust staff and students to be healthy at work.

However, although the economic argument is crucial, the real benefits of our workplace wellness programme have been the social and more intangible benefits. We have created employment opportunities for both Trust staff and community members, saved precious car parking spaces by encouraging active travel, made changes to the physical environment (such as stair signs and motivational posters, a staff wellbeing room, 'smoothie' bars, five-a-day campaigns in the catering outlets etc) and of course, achieved the initial aim of improving the health culture, beliefs and behaviours of Trust staff (Lee et al, 2008).

Despite not being able to provide hard research data on our programme's impact on sickness absence and turnover, we have obtained much qualitative data from participants stating that, since the Trust was going through a very difficult time with staff workloads increasing due to staff shortages, the enjoyable activities provided by Q-active and social support they gained from friends made at the classes were the only reason that they had chosen to continue working for the Trust.

Conclusion

The case for workplace wellness programmes is clear and the need for them within the healthcare sector is irrefutable. However, establishing a localised business case can be problematic in the absence of hard economic data and a strong economic research evidence base. We argue that whilst it is important for employers to fund dedicated posts and provide initial investment, once established, programmes set within large organisations can become vital part of organisations' infrastructure embedded within policies and, if staffed effectively and operated with high-level management support and a business approach, can be self-sufficient and even profit-making.

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